Welfare and Medicaid Coverage of the Poor and Near-Poor in Low-Income Areas

GERALD SPARER and LOUISE M. OKADA

HOW MANY poor persons eligible for welfare have either not applied for or have not received it? How many persons eligible for the Medicaid program have not received these benefits? We usually do not know, since data on the actual number of persons who are eligible but not receiving service under a social program are generally not readily available.

Only for limited geographic areas, are data more readily at hand for comparing, area by area, how well the poor—as defined by a national standard of poverty—are covered by various social programs. From data on program coverage in these small areas, then, we not only can determine the proportion of the poor with coverage in pockets of poverty, but also the proportion that is without coverage.

Moreover, observations based on national, regional, State, or city data frequently cannot be applied to local areas. Measurements of program coverage in larger areas generally just average down the concentration of the population affected. As an example, the percent of persons on welfare in Pennsylvania in June 1969 was 4.5, compared with 25.8 percent in the area of the southeast Philadelphia neighborhood health center surveyed. More specifically, 40.7 percent of the families in one census tract in this city neighborhood were on welfare.

Our study, being based on surveys of small areas, focuses attention on the localities where the poor who are in need of social programs are concentrated. The surveys were undertaken to obtain baseline measures of demographic and socioeconomic characteristics as they related to health levels and health service utilization patterns of the populations of service areas where the Office of Economic Opportunity was planning to establish health programs.

Data on coverage of the population by current programs are useful in planning future health and welfare programs and especially in estimating, in areas where income by family size is known, the expected coverage. Measures of differential coverage by area will also be instructive should program eligibility be based on national standards. Because national consideration is being given to major modifications in welfare (Family Assistance

Mr. Sparer is the director and Mrs. Okada is a statistician, Program Planning and Evaluation Division, Office of Health Affairs, Office of Economic Opportunity.

This paper is one of a series presenting the demographic, socioeconomic, and health characteristics of the populations of small geographic areas. The series is based on data from household interview surveys of these populations. It is sponsored by the Office of Economic Opportunity in conjunction with the funding of neighborhood health center projects.

Tearsheet requests to Gerald Sparer, Program Planning and Evaluation Division, Office of Health Affairs, Office of Economic Opportunity, Executive Office of the President, Washington, D.C. 20506.

Program) and health insurance (Family Health Insurance Program), we may thus profitably examine the experiences of precursor programs (public assistance, other categorical assistance programs, and Medicaid) to analyze their impact on the poor. We can measure this impact by the proportionate participation in a program by residents of low-income areas. Seventeen million of the poor and near-poor (that is, persons of low income) probably live in areas of concentrated poverty, according to a 1967 study conducted for the Department of Health, Education, and Welfare (*1*).

Limitations of Our Study

In our study, we were not able, of course, to take into account all the possibly significant differentials between the areas surveyed. Since a national standard for poverty was used to determine the adequacy of social program coverage, we have not taken account, for example, of differences in the cost of living between areas. The cost-of-living differential, however, rarely varies in urban areas by more than 10 percent from the U.S. average. A Department of Labor index of the comparative costs of living in 1969 for an urban family of four in a number of Standard Metropolitan Statistical Areas gives New York City a value of 102, Philadelphia 99, San Francisco 111, Atlanta 93, and Washington, D.C. 104; the average U.S. urban value is 100 (*2*).

Differences in the composition of the populations in the survey areas also have not been considered, such as the number of households headed by females, large family size, or the number of disabled persons, although such differences might affect program coverage. It is reasonable, however, to assume that the groups toward which the social programs under study are directed, aside from income, should not vary widely in the urban poverty areas except perhaps in the number of elderly persons. With these reservations in mind, one can judge the adequacy of coverage of the poverty population by a given social program without regard for local differences in eligibility.

Source of Data

The National Opinion Research Center collected the small area data on which our report is based in 1968 and 1969 by household interview surveys, using a standard area probability sampling design. Computer support was provided by System Sciences, Inc., Bethesda, Md. The urban areas surveyed consisted of a number of census tracts; the rural areas consisted of several counties. The estimated populations of the survey areas, number and percent of household interviews completed, and number of persons in these households are shown in table 1.

In addition to incomplete interviews, a substantial number of persons refused information on, or did not know, either their annual income or welfare status, or both. All interviews in which the respondents did not provide information on their status as to income, welfare, or primary source of payment for medical care are excluded

Table 1. Total population, completed household interviews, and nonresponses in survey areas

Survey area	Estimated total population	Household interviews completed		Total persons in households interviewed	Persons in households not responding on 3 items [1]	
		Number	Percent		Number	Percent
Bedford-Stuyvesant-Crown Heights, Brooklyn, N.Y.	135,000	1,472	81	4,619	695	15
Red Hook, Brooklyn N.Y.	24,000	1,506	82	5,269	983	19
Southeast Philadelphia, Pa.	31,000	1,404	82	4,644	848	18
Upper Cardozo, Washington, D.C.	44,000	866	71	2,432	329	14
Southside, Atlanta, Ga.	28,000	1,075	92	4,164	135	3
Charleston, peninsula area, S.C.	42,000	1,441	91	4,483	556	12
5 Wisconsin counties [2]	252,000	1,914	92	4,725	602	13
16 eastern Montana counties [3]	85,000	941	(4)	3,088	557	18
Mission area, San Francisco, Calif.	109,000	1,415	77	3,851	895	23
East Palo Alto, Calif.	23,000	1,503	86	4,731	524	11

[1] Items concerned annual income, welfare, and primary sources of payment for medical care.
[2] Clark, Marathon, Portage, Taylor, and Wood Counties.
[3] Indian reservation areas were excluded. The 16 counties were Carter, Custer, Daniels, Dawson, Garfield, McCone, Phillips, Powder River, Prairie, Richland, Roosevelt, Rosebud, Sheridan, Valley, and Wibaux.
[4] Not available.

Table 2. The poor, the near-poor, welfare clients, and Medicaid enrollees as percentages of total population

Survey area	Number in sample population [1]	Poverty groups			Welfare	Medicaid [2]
		Poor	Near-poor	Both groups		
Bedford-Stuyvesant	3,924	22	24	46	31	39
Red Hook	4,286	25	31	57	25	36
Philadelphia	3,796	34	26	59	26	21
Washington, D.C.	2,103	13	16	28	8	9
Atlanta	4,029	36	26	61	21	9
Charleston	3,927	38	23	61	8	4
Wisconsin	4,123	14	18	31	3	3
Montana	2,531	11	14	25	3	3
San Francisco	3,851	13	16	28	16	11
Palo Alto	4,731	10	12	22	18	12

[1] Persons not responding about annual income, welfare, and source of primary payment of medical care are excluded.
[2] The small number of persons covered by both Medicare and Medicaid are excluded.
NOTE: The denominator for each percentage in tables 2–4 is the total population in the area.

from the rest of this report. The number of persons who did not state their source of primary payment for medical care was very small. The total number and percent not providing information on these three items ranged from 135 (3 percent) in Atlanta, Ga., to 980 (19 percent) in Red Hook, a section of Brooklyn, N.Y.

The fact that a higher percentage of the nonrespondents than the respondents had private health insurance suggests that in most geographic areas bias arising from nonresponse served to exclude relatively larger numbers of the near-poor and the nonpoor than the poor. Therefore, both the proportions of the population covered by welfare and Medicaid have been somewhat overstated in most of the survey areas. For the same reason, nonresponse had scarcely any effect on measures of program coverage of the poor.

We used the Social Security guidelines for "poor" (income by size of family) for the fiscal year 1968 or 1969. For a family of four, for example, the annual income cutoff was $3,200 in fiscal 1968; in fiscal 1969, it was $3,300 for nonfarm families and $2,300 for farm families. The near-poor category includes persons in families with incomes up to $2,000 above the level for the poor. The nonpoor category includes all persons in families with incomes higher than the cutoff figure for the near-poor ($5,200 in 1968).

Information on welfare coverage was obtained from responses to the question "Does anyone in the household get any income from welfare?" All persons in families with at least one person receiving welfare income were classified as welfare recipients. Therefore, insofar as the welfare recipient in a household was a relative or unrelated person whose welfare status did not apply to other household members, the welfare figures in our report are inflated.

Data on Medicaid status were derived from responses to the question—"Have you or has anyone in the household been enrolled in Medicaid?" The term "Medicaid coverage" refers to persons enrolled for Medicaid benefits.

Differences between areas in Medicaid coverage may relate, at least partially, to differences in Medicaid enrollment procedures. In some areas, welfare recipients may be automatically covered by Medicaid. To the extent that such persons may not be aware of their enrollment, our estimates of coverage may be low. Overreporting, however, is unlikely. In other areas, Medicaid coverage may not be extended to welfare recipients except upon their application, in which case, application for Medicaid may be related to use of medical services.

The status and number of persons eligible for public assistance and Medicaid fluctuate over time. Changes in employment status or family size may change eligibility and, therefore, the number of persons covered by a program at any point in time will vary. Local and State eligibility requirements also change. Furthermore, Medicaid is a fairly recent program; its inception and development varied among States and cities. For example, the Medicaid program in Washington, D.C., began July 1, 1968, and its enrollment almost doubled within the next 18 months. When the Upper Cardozo area of the city was surveyed in the period January–April 1969, 9 percent of the area population was found to be covered by Medicaid. City figures show that by the end of

1969, the proportion of the population certified as eligible had risen to 16 percent.

In the States surveyed, the Medicaid program became effective on the following dates: California—March 1, 1965; District of Columbia—July 1, 1968; Georgia—October 1, 1967; Montana—July 1, 1967; New York—May 1, 1966; Pennsylvania—January 1, 1966; South Carolina —July 1, 1968; and Wisconsin—July 1, 1966.

Percent of Total Populations Covered

Extent of poverty. The extent of poverty in the total population varied considerably in the survey areas (table 2). In the rural area of Montana, 11 percent of the population was poor, and in the rural area of Wisconsin, 14 percent. In the urban areas, the proportion of the poor in the total population ranged from 10 to 38 percent. Areas where the poor and near-poor together comprised more than 50 percent of the entire population were Red Hook, Philadelphia, Atlanta, and Charleston. Early estimates of concentrated poverty in urban areas made by OEO program officials (primarily those working on Head Start and health programs) had been based on the assumption that 80 percent of the residents would have low incomes or be poor—the distinction was not clear. Our data, however, indicate that such density of poverty in urban areas is likely to be rare.

Although the proportion of the population that was poor in some of those areas was close to the U.S. average of 12.8 percent in 1968 and 12.2 percent in 1969 (*3*), generally the average family income of these areas was lower than the U.S. average (except in east Palo Alto and Montana). The 1970 census data on income by family size for small areas will soon provide us with a clearer understanding of concentrations of poverty in the study areas and other geographic areas of the United States.

Welfare. Welfare coverage was generally greatest in the northeastern United States. The proportion of the total population on welfare in an area was not closely related to the concentration of poverty in the area (table 2). Poor persons not covered by welfare comprised a substantial proportion of the population in some areas (table 3). In Charleston, for example, the poor who were not covered constituted nearly one-third of the entire area population. In contrast, the proportion of the area population in east Palo Alto, the Mission section of San Francisco, and Bedford-Stuyvesant-Crown Heights, Brooklyn, N.Y., that was poor and not covered was fairly low.

Table 3. The poor and near-poor, with and without welfare coverage, as percentages of total area population

Survey area	Poor		Near-poor	
	Welfare	No welfare	Welfare	No welfare
Bedford-Stuyvesant...	15.9	6.4	10.6	13.5
Red Hook.....	15.0	10.2	7.5	23.9
Philadelphia.....	18.7	14.9	4.8	20.8
Washington, D.C.....	5.0	7.8	.7	15.0
Atlanta.....	14.3	22.0	4.0	21.8
Charleston.....	6.6	31.2	.6	22.3
Wisconsin.....	1.2	12.7	.2	17.3
Montana.....	1.8	9.3	.4	13.0
San Francisco.....	6.9	5.6	4.4	11.2
Palo Alto.....	6.1	3.8	3.6	8.2

Table 4. The poor and near-poor, with and without Medicaid, as percentages of total area population

Survey area	Poor		Near-poor	
	Medicaid [1]	No Medicaid [1]	Medicaid [1]	No Medicaid [1]
Bedford-Stuyvesant...	17.6	4.6	14.7	9.4
Red Hook.....	17.1	8.1	13.7	17.7
Philadelphia.....	15.0	18.6	4.4	21.2
Washington, D.C.....	5.7	7.0	1.5	14.2
Atlanta.....	6.5	29.8	1.9	24.0
Charleston.....	3.6	34.2	.2	22.7
Wisconsin.....	.9	12.9	.6	17.0
Montana.....	1.5	9.6	.4	13.1
San Francisco.....	5.0	7.5	3.2	12.4
Palo Alto.....	4.3	5.6	2.6	9.2

[1] The small number of persons covered by both Medicaid and Medicare are excluded.

A number of persons and organizations have suggested that welfare should be extended to the near-poor. In six of the areas surveyed—Bedford-Stuyvesant-Crown Heights, Red Hook, Philadelphia, Atlanta, San Francisco, and Palo Alto—a substantial part of the near-poor population is already included in public assistance programs. The concept of the near-poor is related to the concept of medically needy, which is incorporated into the legislative objectives of Medicaid.

Medicaid. The Medicaid coverage of the total population of an area tended to be similar to the pattern of welfare coverage (table 2). Medicaid coverage was greatest in the urban areas of the Northeast, followed by the two West Coast survey areas. Table 4 shows the proportion of each

area's total population that was poor and near-poor by Medicaid status.

Persons covered by both Medicaid and Medicare have been excluded from our Medicaid figures. Persons covered by Medicare were generally not covered by Medicaid except in Red Hook, where almost one-third of those covered by Medicare were also covered by Medicaid.

The lack of Medicaid coverage, like the lack of welfare coverage, had its greatest impact on Charleston since the poor in that survey area who were not covered by Medicaid constituted one-third, and the near-poor not covered constituted more than one-fifth, of the total population. Altogether, in Charleston, low-income residents (the poor and near-poor) who reported they were not certified to receive Medicaid benefits constituted 57 percent of the entire area population.

Welfare and Medicaid. The poor and near-poor covered by welfare and also certified for Medicaid are shown in table 5 as proportions of the total area population, along with the proportions certified for Medicaid and not on welfare. The elderly who received Medicare benefits are not included since most of the poor and near-poor who have Medicare coverage do not receive welfare or Medicaid benefits.

In general, where welfare coverage was relatively high, Medicaid coverage was also. In Bedford-Stuyvesant-Crown Heights and Red Hook, Medicaid coverage was more extensive than welfare; a large part of the poor and near-poor who were not on welfare were covered by Medicaid. In Philadelphia, nearly three-fourths of those on welfare were also covered by Medicaid, but the coverage of the poor and near-poor not on welfare was much lower than in either of the Brooklyn areas. In Atlanta and Charleston, where welfare coverage in relation to the concentration of poverty in the area was low, about half of the poor on welfare were also covered by Medicaid; very few of the remainder of the poor were enrolled in Medicaid. Only a small proportion of the near-poor in these two urban areas was covered by either program. In the rural areas surveyed, both welfare and Medicaid programs were practically nonexistent.

Coverage of Poor, Near-Poor, and Nonpoor

When the number of poor, near-poor, or nonpoor persons in a survey area was used as the denominator in determining the percentage of program coverage, differences between areas were more striking than when such percentages were based on the area's total population.

Medicaid and welfare. The percentages of the poor and near-poor in each area who were enrolled in, or receiving benefits from welfare, Medicaid, and Medicare are compared in table 6. The coverage of both the poor and near-poor by welfare and Medicaid in New York City was outstanding. The extent of welfare and Medicaid coverage of the poor in the two areas of California was similar to that in Philadelphia and Washington, D.C., but coverage of the near-poor by these programs was superior in California. The

Table 5. Percentages of the poor and near-poor, with and without welfare, who were enrolled in Medicaid, in total area population and in welfare or nonwelfare group

Survey area	Poor				Near-poor			
	Welfare with Medicaid, based on—		Nonwelfare with Medicaid, based on—		Welfare with Medicaid, based on—		Nonwelfare with Medicaid, based on—	
	Total population	Welfare group	Total population	Nonwelfare group	Total population	Welfare group	Total population	Nonwelfare group
Bedford-Stuyvesant	15.4	95	2.8	51	9.7	91	5.5	42
Red Hook	14.0	94	4.3	52	6.3	85	8.5	35
Philadelphia	13.6	71	3.1	23	3.6	76	1.3	6
Washington, D.C	3.3	66	2.7	38	.6	85	1.0	7
Atlanta	6.5	46	.4	2	1.8	49	.1	1
Charleston	3.5	55	.4	1	0	6	.2	1
Wisconsin	.4	44	.5	5	.2	75	.5	3
Montana	1.7	87	0	0	.3	73	.1	1
San Francisco	5.0	70	.4	10	2.7	75	.8	8
Palo Alto	4.2	67	.2	6	2.1	60	.6	8

NOTE: The small number of persons covered by both Medicaid and Medicare are excluded.

percentages of the poor covered by welfare ranged from 8 percent in Wisconsin to 71 percent in Bedford-Stuyvesant-Crown Heights; welfare coverage of the near-poor ranged from 1 percent in Wisconsin to 44 percent in Bedford-Stuyvesant-Crown Heights. Medicaid coverage was more extensive than welfare only in Bedford-Stuyvesant-Crown Heights, Red Hook, and Washington, D.C.

Table 7 presents the percentage distribution for each survey area of the poor and near-poor who were covered by Medicaid and welfare, covered by Medicaid only, covered by welfare only, and not covered by either program.

Medicare among poor and near-poor. The effect of lack of welfare and Medicaid coverage was lessened in some areas by substantial Medicare coverage (table 6). Medicare coverage was especially high in the rural areas surveyed. Nearly one-fifth of the poor and near-poor in the Wisconsin and Montana rural areas were covered by Medicare, and this high coverage is related to the high proportions of the elderly in the poverty groups of these areas.

Private health insurance. Although data on private health insurance is not directly related to coverage by social programs, the surveys provided information on the extent of such insurance in the areas at the three income levels (table 8). In areas with higher welfare and Medicaid coverage, the proportions of the population with private insurance were generally lower than in areas covered less well by these programs. In Wisconsin and Montana, a high proportion of the poor and near-poor, as well as of the nonpoor, had private health insurance. Among the nonpoor, private health insurance coverage ranged from a low of 50 percent in Atlanta to a high of 85 percent in Wisconsin. Information on private insurance coverage was obtained from responses to the questionnare item, "Not counting Medicare, Medicaid, does any member of this household have any insurance that pays all or part of the medical bills when they go to the hospital or doctor—such as Blue Cross/Blue Shield, a commercial plan, a union plan, or some other plan?"

Third-party payment. Medical care coverage of the total area population by third-party pay-

Table 7. Percentage distribution of the poor and near-poor, by program coverage status

Survey area	Welfare and Medicaid [1]	Medicaid only [1]	Welfare only	Neither program
	Poor			
Bedford-Stuyvesant	71	13	4	12
Red Hook	60	18	4	17
Philadelphia	42	10	17	31
Washington, D.C.	27	22	14	36
Atlanta	18	1	21	60
Charleston	10	1	8	81
Wisconsin	4	4	4	88
Montana	17	0	3	80
San Francisco	46	4	18	32
Palo Alto	42	2	21	35
	Near-poor			
Bedford-Stuyvesant	41	23	4	32
Red Hook	20	27	4	49
Philadelphia	14	5	5	76
Washington, D.C.	4	7	1	89
Atlanta	7	1	8	85
Charleston	0	1	2	97
Wisconsin	1	3	1	95
Montana	3	1	1	95
San Francisco	20	6	7	67
Palo Alto	19	5	12	64

[1] The small number of persons covered by both Medicare and Medicaid are excluded.

NOTE: The four percentages for an area may not add to 100 because of rounding.

Table 6. Percentages of the poor and near-poor in each survey area covered by welfare, Medicaid, and Medicare

Survey area	Poor			Near-poor		
	Welfare	Medicaid	Medicare [1]	Welfare	Medicaid	Medicare [1]
Bedford-Stuyvesant	71	79	6	44	61	4
Red Hook	60	68	14	24	44	7
Philadelphia	56	45	14	19	17	12
Washington, D.C.	39	45	10	5	9	10
Atlanta	39	18	7	16	7	7
Charleston	17	9	12	2	1	10
Wisconsin	8	6	21	1	3	20
Montana	16	14	19	3	3	19
San Francisco	55	40	2	28	21	3
Palo Alto	62	43	2	31	23	6

[1] Includes persons who had both Medicare and Medicaid.

NOTE: The denominator for each percentage in tables 6–9 is the poor, near-poor, or nonpoor group.

ment (both public and private) was lowest in the Atlanta neighborhood area. Altogether, 53 percent of this area population had no health care coverage. In contrast, only 10 percent of the total population of the Wisconsin area lacked such coverage.

Moreover, despite the differential mix of public programs and private health insurance, the proportions of the poor having no health care coverage ranged from 11 percent in Bedford-Stuyvesant-Crown Heights and Red Hook to 60 percent in Charleston; the proportions of the near-poor in this category ranged from 14 percent in Wisconsin to 58 percent in Atlanta and Charleston; and the proportions of the nonpoor in this category ranged from 9 percent in Wisconsin to 44 percent in Atlanta (table 9).

Implications of Study Data

Current welfare and Medicaid assistance programs have been differently implemented by States and local governments. Therefore, the establishment of a single national standard of effective eligibility for both programs would have a differential effect on State and local financing and on local coverage. New York City has had the broadest coverage of the areas surveyed and, in these areas at least, as geographic distance southward from New York City increased, so did the gap between income status and participation in financial and assistance programs (including Medicaid). The coverage in the California survey areas appears to have been similar to that in the Philadelphia area. Only in New York, has the concept of the medically needy been implemented in the Medicaid program coverage.

In the currently proposed Family Assistance Program and Family Health Insurance Program, $2,400 for a family of four persons is being considered as a national eligibility criterion. Under the proposed guidelines for these new programs, presumably at least 50 percent of the poor of each State and local jurisdiction would be eligible. The Federal outlay would underwrite 100 percent of these costs; thus, there could be a significant influx of Federal dollars to rural and lower income States. Participation in the basic Family Assistance Program and Family Health Insurance Program, as distinguished from current public assistance and Medicaid programs, would similarly increase in these areas.

These proposed programs would have significant social and political implications and, in the health arena, significant implications for the redistribution of resources. Establishment, nationally, of a floor for income assistance would significantly increase participation among the lower income States—southern and rural States in general. Thus, New York, and perhaps Illinois, Pennsylvania, and California, which seem to be the States with the heaviest investment in social support programs, would need funds in excess of those provided for in the basic Family Assistance Program if they were to maintain current income assistance coverage.

The effect of the proposed Family Health Insurance Program is not clear. Money can more easily be redistributed than health care services. While the proposals for redressing the imbalance in health financing between the economically more able and the economically less able States is a step in a socially desirable direction, factors other than financial will limit such action.

In many of the States where the financial support available for the medically needy would increase significantly, there might be no real increase, even within 5 to 10 years, in the availability of resources, manpower, and facilities to deliver the needed services. Under these condi-

Table 8. Percentages of the poor, near-poor, and nonpoor with private health insurance

Survey area	Poor	Near-poor	Nonpoor
Bedford-Stuyvesant	4	16	58
Red Hook	8	28	63
Philadelphia	13	44	67
Washington, D.C.	6	29	54
Atlanta	17	28	50
Charleston	19	31	63
Wisconsin	61	63	85
Montana	42	46	76
San Francisco	11	29	69
Palo Alto	14	33	69

Table 9. Percentages of the poor, near-poor, and nonpoor without either public or private health insurance coverage.

Survey area	Poor	Near-poor	Nonpoor
Bedford-Stuyvesant	11	19	27
Red Hook	11	21	21
Philadelphia	29	27	23
Washington, D.C.	39	51	39
Atlanta	57	58	44
Charleston	60	58	30
Wisconsin	12	14	9
Montana	25	31	17
San Francisco	29	29	23
Palo Alto	40	39	23

tions, the increased ability to pay for services would very likely only further shift payment from local to Federal sources and more important, produce the same, or an even more pronounced, inflationary cycle in medical care costs than has attended the advent of Medicare and Medicaid, even in urban areas with higher medical resources. Proposals to shift manpower to areas deficient in health resources and to provide front-end funding for facilities and staffing are important adjuncts to financing. Without such outlays of resources, the Family Health Insurance Program (which would only provide financing) could further compound the health care crisis in areas with scarce resources.

REFERENCES

(*1*) Burt, M. R., et al.: Delivery and financing of health services to the poor. A cost-effectiveness analysis. Report prepared by Resources Management Corporation, Bethesda, Md., for Office of the Secretary, Health, Education, and Welfare, Washington, D.C., Aug. 31, 1967.

(*2*) Bureau of Labor Statistics, U.S. Department of Labor: Three budgets for an urban family of four persons: final spring 1969 cost estimates. Washington, D.C., December 1970.

(*3*) U.S. Bureau of the Census, U.S. Department of Commerce: Poverty increases by 1.2 million in 1970. Current Population Reports P–60, No. 77. Washington, D.C., May 7, 1971.

SPARER, GERALD (Office of Economic Opportunity), and OKADA, LOUISE M.: *Welfare and Medicaid coverage of the poor and near-poor in low-income areas. HSMHA Health Reports, Vol. 86, December 1971, pp. 1099–1106.*

Data on poverty and on program coverage by social programs were collected by means of household interview surveys in 10 low-income neighborhoods or areas as the Office of Economic Opportunity prepared to put health service programs into operation in the areas.

The concentration of the poverty population as defined nationally by the Social Security Administration varies considerably from area to area. The proportion of the population classified as poor ranged from 10 to 38 percent of the total population of the survey areas. The poor and near-poor together comprised from 21 to 61 percent of these populations.

Program coverage was viewed from the perspective of the entire neighborhood or area and according to income levels. The results gave a cross-sectional view of the participation (that is, the proportion of persons receiving benefits or enrolled to receive benefits) in long-term Federal and local programs designed to assist the poor and near-poor.

The extent of coverage by welfare and Medicaid in any one area was generally about equal. Both welfare and Medicaid coverage was highest in the New York City area and decreased southward; the California urban areas were about equal in coverage to the Philadelphia area. At the low end in coverage were Atlanta, Charleston, and the two rural areas of Wisconsin and Montana.

Information regarding area variations in the concentration of poverty and in the differential coverage by social programs is useful in policy and program planning at both the national and local levels.